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The Future of Clinical Leadership: Evidence for Physician Leadership and the Educational Pathway for New Leaders

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Abstract

Until recently, the title ‘physician leader’ was rarely heard particularly in the U.K. But that is changing. Doctors are being drawn into leadership and management more systematically. New educational opportunities are being tailored to the specific needs of doctors. The change towards physician leadership is being driven by research showing that leaders who are experts in the core business, such as doctors, are associated with improved organisational performance. This article summarises that evidence and then reviews what we have learned about how best to train future physician leaders.

Introduction

Until recently, the title ‘physician leader’ was rarely heard. Naturally, this was not the case in those institutions like the Cleveland Clinic and Mayo Clinic which have been physician-led from the beginning. But in the U.K.’s National Health Service (NHS), and among many U.S. health care organisations, the CEO was, and still is, more likely to be a non-clinically trained professional manager instead of a doctor. Indeed, the term ‘physician leader’ was viewed as almost politically incorrect. It was deemed as insulting to senior executives who were business managers, nurses, or other allied professionals; and in a Darth Vader-esque narrative, physicians who assumed administrative leadership roles were considered to have gone to “the dark side.”

But something has changed. The web is full of articles, conference announcements, and educational opportunities for doctors going into leadership. The research evidence, whilst still sparse, is growing. To precisely attribute the actions of institutional heads to the performance outcomes of their organizations is extremely difficult. Sadly, in social science, unlike in medicine, it is not possible to randomly assign a physician leader to a hospital. But despite the many

intervening variables muddying the water, patterns are emerging. The rationale for physician leadership is growing.

The Case for Physician Leadership

In a recent article, Sarto and Veronesi review the case for ‘clinical leadership and hospital performance’ (1). The authors assess physician leadership at the level of CEO, clinical director, and participants on hospital governing boards and quality committees. The performance measures include financial and resource management, the quality of care, and hospital social performance, which is a multi-dimensional construct that captures the relationship between hospital expenditure and benefits to local communities. The review findings, based on 18 studies, support the case for physician leadership.

The Theory of Expert Leadership (TEL) is another line of evidence that supports physician leadership (2). The theory suggests that a leader should have deep knowledge of the core business of the organization that he or she is to lead. This line of research began by identifying simple patterns. For example, in health care, it was observed that the top 100 hospitals in the U.S. were statistically more likely to be led by physicians instead of non-medically trained managers. Specifically, among U.S. News and World Report ranked hospitals in 2009, leadership by a physician CEO (vs. a non-physician manager) was strongly associated with top quartile performance; quality scores were approximately 25% higher (3). In other settings, but this time using longitudinal data with many confounding variables, expert leaders have been shown to be associated with improved organizational performance – these include presidents and department heads in research universities (4,5), Formula 1 heads (6), and basketball coaches (7). It is also clear that expert leaders are not merely people who dabbled in the core business activity for a short time and then switched to management. Academics in administrative positions in universities who gave up their own research activities early in their career, have been shown to be associated with universities that performed the least well over a ten-year period (8). Similarly, the physicians in the top-100 U.S. News and World Report ranking mostly had long practice careers and many were also highly cited researchers.

How expert leaders exert this organizational effect has been the subject of more recent research. In a study that includes random samples of 35,000 U.S. and U.K. workers matched with their employers, the influence on job satisfaction of an employee's immediate boss is examined. Expert bosses are strongly associated with high levels of employee job satisfaction; indeed, boss competence is more important than pay (9). Furthermore, and in a healthcare setting, the leadership qualities of physician supervisors have also been found to influence clinician job satisfaction and well-being (10). These findings have important implications for the selection and training of physician leaders, and provide new insights into organizational factors that affect physician well-being and overall productivity. Job satisfaction rates are known to be important for individual and organizational performance (11-14).

In new research that examines faculty in universities, we again find that employees report higher levels of job satisfaction and also lower intentions to quit when they are led by core business experts (heads of departments who are distinguished researchers)(15). In the same study the possible channels of influence between an expert manager and an employee are examined. A number of positive factors are revealed: they include better feedback, allow more autonomy, greater consultation, understand the nature of the work, raise levels of morale in the workplace, and greater attractiveness of the workplace to outsiders. Arguably a physician CEO may appear more credible to clinical followers both inside and outside the organization. If an outstanding psychiatrist is the CEO of a major psychiatric hospital, this is likely to signal to new hires that the boss understands the nature of the job, and, therefore, that employees may expect a sympathetic work environment.

Beyond these observations that inform the Theory of Expert Leadership, a further rationale for training physicians to lead (and, as a corollary of leadership, to follow) is that traditional medical training crafts doctors as "heroic lone healers" who may be "collaboratively challenged." This notion was articulated as early as 1976 by Marvin Weisbord who noted that "Science-based professional work differs markedly from product-based work. Health professionals learn rigorous scientific discipline as the "content" of their training (16). The 'process' inculcates a value for autonomous decision-making, personal achievement, and the importance of improving their *own* performance, rather than that of any institution." Revamping cultures of training physicians again requires adept leadership by physicians.

A major attribute of these senior leaders is their sense of organizational altruism, a commitment to “give back” and to assume roles as “servant leaders” who are in service of the organization’s needs over their own. This commitment to altruism distinguishes senior leaders’ impressions from more junior aspirants to leadership roles. Physician leaders who have successfully evolved into leadership roles in health care organizations can model their leadership behaviours and reframe their junior colleagues’ impressions about effective leadership competencies – altruism, emotional intelligence, teamwork, effective communication, and adeptness at situational leadership (in which the correct leadership style is deployed for the correct circumstance). In such a world, the “command and control” leadership style that it seems has dominated traditional academic medicine begins to look different as both the “hidden” and explicit curricula of medical leadership training.

Educating Future Physician Leaders

Thankfully, there seems to be an increasing appetite among physicians to develop their leadership skills and to assume leadership roles. But a paradox continues to pervade healthcare. On the one hand, interdisciplinary teamwork is critically important to realize the patient outcomes that all doctors care about deeply – our patients’ survival, their improved well-being, and an enhanced and optimal patient experience. Furthermore, in the context of the “triple aim” to provide high quality care that includes high patient satisfaction, patients’ experience of their health care (17) is strongly related to their perception of teamwork among their caregivers. (18).

On the other side of this paradox, despite the primacy of teamwork in health care, forces are at play that conspire against teamwork among physicians. (19-21) Specifically, health care organizations, and in particular hospitals, are classically siloed and doctors have been traditionally organized in “tribal” ways around their specialty and pedigree. Organizational constructs like traditional departments of medicine and surgery, which are organized around common specialties - while logical in their origins - subtly discourage collaboration across specialties. Consider the perennial squabble about “fleas” and “blades” which, on the one hand, can be dismissed as harmless banter but can also be construed as articulating “tribalism.” Another siloed structure is the separated leadership of major units in health care organizations, like the hospital versus the medical school versus the faculty practice plan, which can also conspire against optimal teamwork.

Against this background, there is a critical need to reframe both the structures within health care and the processes by which physicians, in particular, are selected and trained. Thankfully, through mindful leadership to date, change in these processes is currently under way; for example, there is increased emphasis on human and interpersonal skills on the Medical College Achievement Test for medical school admission. Also, many medical school curricula and cultures are newly emphasizing teamwork and collaboration. Yet, more pervasive change is needed.

Medical education and training should ideally be led by physicians. Major change initiatives like enhancing teamwork and collaboration among physicians, breaking down traditional silos in healthcare organizations, and achieving the triple aim requires expert, hard-won leadership skills - often the product of formal curricula, mentorship and coaching by role models, and by experiential learning in progressive leadership roles. So, several questions arise that are the subject of this perspective piece. Specifically: What are the leadership competencies that are needed? How should physician leadership best be taught? And how do we know if it is working?

Competencies for Leadership

The rationale for committing to develop physician leaders is simply that leadership competencies matter and differ markedly from the clinical and scientific competencies on which physician's train to practice medicine or do research. The time and attention that most clinicians give to learning medicine during their training eclipses any attention that they can give to learning these leadership competencies (22,23). Thus, learning opportunities must be made available at other times. Also, evidence shows that leadership competencies, while not usually included in medical school or GME curricula, can be learned (24). For example, Boyatzis has shown that, as assessed by a standardized 360° evaluation instrument, both Self-Awareness and Management as well as Social Awareness and Relationship Management can be sustainably enhanced for up to 7 years following training on mindfulness (25). Furthermore, the weight of evidence and leadership opinion suggests that although some people have a greater natural proclivity to lead, leadership can be developed (26).

How then should leadership be developed? Three components comprise an ideal leadership development strategy: a curriculum of leadership competencies; offering developmental

relationships, often through supportive coaching and mentoring; and offering progressive and challenging leadership opportunities (27). Rabin at the Center for Creative Leadership has estimated the relative contributions of each of these elements to leaders' success; 10% is ascribed to a didactic curriculum, 20% to supportive relationships, and 70% to experiential leadership opportunities (28).

Ample attention has been given to leadership competencies in health care and many proposed models have emerged. (23) For example, the National Center for Healthcare Leadership model bundles 26 individual competencies into 3 rubrics: transformation, execution, and people (29.) At the Cleveland Clinic, the model used in designing its leadership curriculum is organized around 5 pillars, 9 including emotional intelligence, which subsumes 18 competencies within 4 quadrants: self-awareness, self-management, social awareness, and relationship management (30).

Based on a systematic review of best-in-class leadership development programs, Day and Halpin (31) have articulated the features of an ideal leadership development program (Table 1). Indeed, although only a minority of health care organizations are offering leadership development programs intramurally (32), many of those which do (33-39) have incorporated the proposed design elements. These include medical societies (e.g., American Thoracic Society, United States Canadian Academy of Pathology, American College of Chest Physicians, American Association for Physician Leadership), medical schools and healthcare organizations (e.g., Cleveland Clinic, Mayo Clinic, Virginia Mason, McLeod Health, Hartford HealthCare, Drexel University College of Medicine, Aurora Healthcare, Emory University's Woodruff Health Sciences Center, etc.), and business schools – often in affiliation with health care organizations (e.g., Harvard Business School, The Wharton School of the University of Pennsylvania, Weatherhead School of Management of Case-Western Reserve University, and London's Cass Business School of City, University of London).

With all the money and attention that is focused on leadership development, it is important to ask what effect this training is having on physicians and their healthcare systems.

A U.K. study by Cambridge researcher Jaason Geerts has reviewed the literature on leadership development for doctors applying the Medical Education Research Study Quality Instrument (MERSQI), a validated assessment tool. Only twenty studies met the criteria, which suggests a need for more and better research. Conclusions from the review suggest that video-taped

simulations with peer and expert feedback can lead to improvement in observable leadership behaviour, and action learning projects that are included in the leadership curriculum can be highly effective in demonstrating outcomes at the organisational and clinical (benefit to patients) levels. These are particularly effective when supported by 360-degree feedback, coaching, and mentoring. The best results, the study suggests, come from outcomes-based interventions. Thus, the desired post-programme outcomes are identified at the kick-off -- for the individual, the organisation, and for each clinical level -- and then the programme and the corresponding developmental activities are designed to reflect the desired outcomes (40).

A second systematic review of 45 studies by Frich and colleagues found that only 6 (7.5%) assessed system-level impact (which included quality of care process measures, promotion to leadership of course participants, improved clinical quality metrics in specific diseases [e.g., diabetes, asthma, breast cancer], patient satisfaction, and implementation of business plans developed during a leadership development course.) A subsequent study followed 272 physician leadership course participants over a decade post-course and reported that 43% were promoted to a leadership position over that time (41).

Notwithstanding these few assessments, important gaps in understanding persist. Do graduates of physician leadership programs effect favourable change in their organizations? Are such leadership development programs cost-effective, i.e., does the financial impact of changes that are ascribable to the course offset the cost of offering the training (which includes the opportunity costs of taking physicians “off line”)? What is the optimal method to deliver a physician leadership development curriculum? Recognizing that such training should likely begin early in medical training, what is the ideal “spiral curriculum”? (42,43) How should the didactic curriculum be best integrated with mentoring and coaching of emerging leaders and with a program of progressive, experiential leadership to optimize developing a leadership pipeline?

The imperative to develop leaders in health care who can address the challenges of the triple aim mandates answers to these questions, and the acuity of the need suggests that the “plane must be built while we are flying it.” All aboard!

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Table 1. Features of an Ideal Leadership Development Program (After Reference 15)

- An influential champion, the higher placed, the better (ideally CEO)
- Perception that leadership is needed throughout the organization, not only by a select few (leadership capacity is everywhere)
- The development program must be tied to a current business imperative (e.g., globalization, growth, etc.).
- Programs must be integrated as a process in an over-arching strategy, not as standalone activities.
- Location off-site is preferable.
- Dedicated facilities (e.g., Crotonville) demonstrate the organization's commitment to the process.
- Patience by organizational leadership. The dividends may take a long time to be realized.

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